MARYLAND
Health Care
Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

February 23, 2022

The Honorable Delores Kelley
Chair, Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401

RE: SB 734 - Health and Health Insurance – Primary Care Reform Commission

Dear Chair Kelley:

The Maryland Health Care Commission (MHCC) is submitting this letter of support with amendments on *SB 734 – Health and Health Insurance – Primary Care Reform Commission (SB 734).* The MHCC endorses the aims of SB 734 but believes formation of a new single-purpose Commission to study primary care issues is not needed.

SB 734 establishes a Primary Care Reform Commission composed of 13 members; three (3) appointed by the Governor, four (4) appointed by the President of the Senate, three (3) appointed by the Speaker of the House, and one (1) member each appointed by the Maryland Hospital Association, MedChi, and the Maryland Nurses Association. The primary responsibility of the Commission is to review and make recommendations on the level of primary care spending relative to overall health care spending for all payors. The Commission must also make recommendations on expanding access to primary care, lowering overall costs, and increasing health equity while reducing health disparities. The Commission would develop a uniform definition for primary care, a question on which the clinical care and health services research communities have produced multiple definitions.

The MHCC believes that examining primary care spending as a percent of total health care spending can be a valuable tool for assessing access to primary care and for measuring the overall effectiveness of a health care system. Primary care experts, beginning with Dr. Barbara Starfield, documented that increased investment in primary care could have a beneficial effect on the quality of care, access to care, and mortality. Starfield and colleagues went on to document that the effectiveness of health care systems in the United States and across developed countries could be measured by the percent of health care dollars

dedicated to primary care.[1] [2] [3] Starfield articulated the four pillars of primary care practice: contact care, continuity of care, comprehensive care, and coordination of care. These pillars have been the foundation for all elaborations of the key primary care attributes that provide the basis for launching multiple primary care interventions. Drs. Thomas Bodenheim, Kevin Grumbach and colleagues posited 10 building blocks of high-performing including four foundational elements — engaged leadership, data-driven improvement, empanelment, and team-based care that assist the implementation of the other six building blocks — patient-team partnership, population management, continuity of care, prompt access to care, comprehensiveness and care coordination, and a template of the future.[4] Greater primary care physician supply was associated with lower mortality, but primary care providers per capital have decreased from 2002 to 2016 and prospects for greater supply in the future without major interventions appear dim.[5] Other experts have voiced alarm as the percent of total health care spending attributed to primary care continues to decline. [6]

Primary care experts research has spawned a host of primary care models including patient-centered primary care homes, the Maryland Primary Care Program, and the CareFirst primary care model. These models resemble models being tested elsewhere, the MDPCP closely aligns with current CMS primary care programs such as Comprehensive Primary Care Plus and the recently launched CMS Primary Care First Program. The Maryland Total Cost of Care Model has as a core feature the elevation of primary care and MDPCP is a central element of the broader model. Programs and many others have yielded some successes and demonstrated the importance of primary care on improving population health. Given decades of under investment in primary care, none has yet yielded the health policy

[1] Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. The Milbank Quarterly, 83(3), 457-502. https://www.milbank.org/wp-content/uploads/2020/04/STARFIELD_et_al-2005-Milbank_Quarterly.pdf

[2] Shi, L., B. Starfield, B. Kennedy, and I. Kawachi. 1999. ''Income Inequality, Primary Care, and Health Indicators.'' Journal of Family Practice 48 (4):275–84.

[3] Macinko J, Starfield B, Shi L, "The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD)Countries, 1970–1998", Health Service Research Review, https://onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.00149

[4] Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K, The 10 Building Blocks of High-Performing Primary Care, Annals Of Family Medicine, Vol. 12, No. 2, March/April 2014, https://www.annfammed.org/content/12/2/166, accessed February 20, 2022

[5] Basu S, Berkowitz S, Phillips R, Bitton A, Landon B. Phillips R, Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015 JAMA, February 18, 2019, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2724393

[6] Martin S, Phillips R, Petterson S, Levin Z, Bazenmore A, Primary Care Spending in the United States,2002-2016, JAMA Internal Medicine, Vol. 180, No. 7, Https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2765245

homerun that advocates have promised. Rather than abandon efforts and watch the slow demise of primary care, more progress and new efforts are needed.[7] [8]

Setting spending floors for primary care is one such approach. Rhode Island, Oregon, and Connecticut have taken a direct approach to rectifying under investment in primary care.[9] These states have established minimum thresholds for primary care spending expressed as a percent of total health care spending.

MHCC supports studying access to primary care and developing recommendations to improve access. MHCC believes that a better approach to examining these questions is to direct the MHCC in consultation with the Health Service Cost Review Commission, with the Maryland Department of Health (MDH) and the Maryland Insurance Administration (MIA) to develop a workgroup to study these issues and develop recommendations by the end of 2023. The MHCC has experience with primary care models as MHCC launched the first PCMH program in 2012 after the General Assembly passed legislation establishing a Patient Centered Medical Home (PCMH) pilot. Most notably that program is the primary care program that required the five largest commercial carriers and the Medicaid MCOs to participate.

More recently, the MHCC has been engaged with the MDPCP program since its inception and currently manages the MDPCP Advisory Council, a blue-ribbon workgroup composed of 20 members including some of the leading primary care experts in the country, local experts, payor representatives, and primary providers participating in the MDPCP. Other key participants on the Council include the MDPCP Program Management Office (PMO) and HSCRC. HSCRC's participation is essential because it has developed care transformation programs that complement the MDPCP. HSCRC's participation has ensured that transformation made in the delivery of primary care services align with current and future Total Cost of Care contracts between Maryland and CMS.

MHCC and HSCRC possess analytic and actuarial staff necessary to conduct the assessment of primary care spending relative to total health care spending. MHCC has responsibility for building the Medical Care Data Base (MCBD), which is Maryland's version of an All-Payer Claim Database. The MCDB is used by the HSCRC, MIA, Medicaid

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[7] Sinaiko A, Landrum MB, Meyers D, Alidina S, Maaeng D, Friedberg M, Kern L, Edwards A, Flieger SP, Houck P, Peele P, Reid R, McGraves-Lloyd, Finison K, Rosenthal M, "Synthesis Of Research On Patient-Centered Medical Homes Brings Systematic Differences Into Relief", Health Affairs, Vol 36, NO. 3 (2017): 500–508 healthaffairs/doi/10.1377/hlthaff.2016.1235

[8] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/259

[9] Bailit M, "How States Are Increasing Their Investment in Primary Care", Milbank Memorial Fund, Nov. 19, 2020. https://www.milbank.org/2020/11/how-states-are-increasing-their-investment-in-primary-care/

Administration, and the Maryland Health Benefit Exchange. MHCC released a study of primary care spending as a percent of total spending that mirrors the types of analyses needed to determine possible spending floors for primary care.[10] More recently, MHCC's MCDB contractor worked with six states in New England to develop a comparative report on primary care spending for those states.[11] Other researchers have sought to assess the level of primary care spending using different data sources [12] [13] The MHCC contends that establishing a new commission and directing it to assemble claim data from commercial payors and MCOs is unnecessary and likely duplicative.

MHCC supports the objectives of SB 734. A more cost-effective approach is to ask the agencies already engaged in this work to form a workgroup, study the issue, and report recommendations back to the Committees in December 2023. A letter from the Chairs of Senate Finance and the House Health and Government Operations Committee to MHCC, HSCRC, the Department, and the MIA would be sufficient to engage the respective organizations if the Committee believes legislation is not necessary. For these reasons, we respectfully request the attached amendments.

We hope this information is helpful. If you would like to discuss this further or have any questions, please contact Tracey DeShields, Director, Policy Development and External Affairs at tracey.deshields2@maryland.gov.

Sincerely,

Andrew Pollack
Chair, MHCC

Ben Steffen
Executive Director, MHCC

cc:

The Honorable Clarence Lam, Senator
Heather Shek, Director, Office of Governmental Affairs, MDH
Tracey DeShields, Director, Policy Development and External Affairs, MHCC

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[10] ~~MHCC~~, Primary Care Spending Relative To Total Medical And Outpatient Prescription Drug Spending In Maryland's Privately Insured Markets, 2018, August 2020. https://mhcc.maryland.gov/mhcc/pages/plr/plr_healthmd/documents/cais_Primary_Care_Issue_Brief_08212020.pdf

[11] The New England States' All-Payer Report on Primary Care Payments, The New England States Consortium Systems Organization (NESCSO). Note NESCSO includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf

[12] Pearson E, Frakt A, Health Care Cost Growth Benchmarks in 5 States, JAMA, August 11, 2020, Vol 324, No. 5, https://jamanetwork.com/journals/jama/fullarticle/2769252

[13] Reiff J, Brennan N, Biniek J, Primary Care Spending in the Commercially Insured Population, JAMA December 10, 2019,vol 322,No. 22. https://jamanetwork.com/journals/jama/fullarticle/2757218

MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

MHCC Amendments SB 734

AMENDMENT NO. 1

On pages 1 through 6, strike in their entirety the lines beginning with line 16 through line 8 on page 6, inclusive.

AMENDMENT NO. 2

On page 6, in lines 10 and 17, in each instance, strike "**COMMISSION**" and substitute "**MARYLAND HEALTH CARE COMMISSION**".

AMENDMENT NO. 3

On page 6, strike in their entirety, lines 18 through 22, inclusive, and substitute "**SECTION 2. AND BE IT FURTHER ENACTED THAT THE MARYLAND HEALTH CARE COMMISSION SHALL FORM A WORKGROUP TO DEVELOP THE STUDY, INTERPRET THE RESULTS,AND MAKE RECOMMENDATIONS. THE WORKGROUP SHALL INCLUDE REPRESENTATIVES FROM THE DEPARTMENT INCLUDING THE PROGRAM OFFICE OF THE MDPCP, THE HEALTH SERVICES COST REVIEW COMMISSION, THE MARYLAND INSURANCE ADMINISTRATION, REPRESENTATIVES OF THE PRIMARY CARE COMMUNITY, AND HEALTH SERVICES RESEARCHERS WITH EXPERTISE IN PRIMARY CARE.**"

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ISSUE BRIEF

PRIMARY CARE SPENDING RELATIVE TO TOTAL MEDICAL AND OUTPATIENT PRESCRIPTION DRUG SPENDING IN MARYLAND'S PRIVATELY INSURED MARKETS, 2018

Maryland Health Care Commission

CENTER FOR ANALYSIS AND INFORMATION SYSTEMS

August 2020

ISSUE BRIEF

Primary Care Spending Relative to Total Medical and Outpatient Prescription Drug Spending in Maryland's Privately Insured Markets, 2018

Takeaways

- The primary care spending percentage in Maryland was less than half the average spending on primary care in over 20 industrialized nations (14%).
  - Major contributors to this finding include increased health care costs, reduced primary care service utilization, and a reduction in primary care workforce.

- In Maryland, primary care alone constituted about 4.6% of all medical and outpatient prescription drug spending in 2018, which was comparable to national benchmark percentages of 6.0 (4.6 - 7.6) for PPO plans and 6.5 (3.1 - 9.2) for HMO plans.

- MHCC commenced tracking of primary care spending in the "*Spending and Use among Maryland's Privately Insured,* 2018" (PI Report). Key findings from the report are as follows:
  - Privately insured enrollees ages 0-18 years are more likely to receive primary care services (12%) compared to other age groups (less than 6%).
  - In 2018, PPO and EPO plans spent 4.2% and 4.6%, respectively on primary care while HMO plans spent 5%. These data were comparable to national benchmark percentages reported by the Milbank Memorial Fund.

- Recommendations for increased spending on primary care include:
  - Increased reporting and tracking of primary care spending
  - Enactment of legislation that will promote utilization of primary care services
  - Mandating fully insured health plans to set higher measurable targets for primary care spending

The Issue

The United States spends about **50%** less on primary care services out of total medical spend compared to other industrialized nations, and this is one of the reasons why the cost-effectiveness of US health systems continues to lag.[1, 2] Recent studies have shown that relatively high investment in primary care spending is associated with more top-quality care and a reduction in the overall cost of care.[3] A dozen states track primary care spending in the private market and in Medicaid. Among this group, several states have set floors on primary care spending on private health insurance contracts issued in their states.[4] Key factors relating to the availability and utilization of primary care services are described below.

- **Increased Cost**: The rising cost of care has impacted access to primary care health services. In 2007, only 15% of the US population were enrolled in high deductible health plans (HDHP) compared to **43%** in 2017.[5] The number of visits to primary care physicians are lowest for members enrolled in high deductible plans compared to enrollees with low or no deductible health plans.[5]

- **Reduced Utilization:** The number of individuals with a primary care provider **dropped** by two percent between 2002 and 2015.[6] For adults who consult with primary care providers, the proportion of individuals that received all high-priority recommended preventive services remains low. Studies based on the 2015 Medical Expenditure Panel Survey (MEPS) reported that only **eight percent** of US adults ages 35 and older received all high-priority recommended preventive services.[7] Visits for primary care services among the privately insured declined from 170 to 134 per 100 member-years between 2008 and 2016.[6] During the same study period, the proportion of adults who did not visit a primary care provider increased by 8%. Conversely, visits to urgent care facilities increased by 47% while specialists' visits remained stable.[8]

- **Reduction in Primary Care Workforce**: Even though the demand for primary care is projected to grow with time, the number of primary care physicians dropped from 47 per 100,000 in 2005 to 41 per 100,000 in 2015.[3] Studies show that the number of primary care physician jobs grew by **eight percent** from 2005 to 2015; however, the number of jobs for specialist physicians grew about six times that of primary care physicians. Career dissatisfaction or burnout has also been

[1] Koller, C.F., Khullar, D. (2017) Primary Care Spending Rate — A Lever for Encouraging Investment in Primary Care, NEJM, 377:1709-1711. Retrieved 05/28/2020 from: https://www.nejm.org/doi/10.1056/NEJMp1709538
[2] OECD, (2019). Deriving Preliminary Estimates of Primary Care Spending under the SHA 2011 Framework. P.10. Retrieved 06/03/2020 from: https://www.oecd.org/health/health-systems/Preliminary-Estimates-of-Primary-Care-Spending-under-SHA-2011-Framework.pdf
[3] Basu, S., Berkowitz, S.A., Phillips, R.L., et al (2019). Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. JAMA Intern Med. 2019;179(4):506-514. Retrieved 05/28/2020 from: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2724393
[4] Primary Care Collaborative (2020). State Leadership Highlights. Retrieved 07/07/2020 from: https://www.pcpcc.org/sites/default/files/resources/PCC%20Fact%20Sheet_State%20PC%20Investment%20%28Mar%202020%29.pdf
[5] Editorial (2019). Prioritizing Primary Care in the USA. Vol 394, (10195), p.273. Retrieved 06/04/2020 from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)31678-2/fulltext
[6] Levine,D.M., Linder, J.A., Landon, B.E. (2019). Characteristics of Americans With Primary Care and Changes Over Time, 2002-2015. JAMA Intern Med. 2020;180(3):463-466. doi:10.1001/jamainternmed.2019.6282
[7] Borsky, A., Zhan, C., Miller, T. (2018). Few Americans Receive All High-Priority, Appropriate Clinical Preventive Services. Health Affairs, Vol 37 (6). Retrieved 05/28/2020 from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1248
[8] Ganguli, I., Shi, Z., Orav, J., Rao, A., Ray, K.N. (2020). Declining Use of Primary Care Among Commercially Insured Adults in the United States, 2008–2016. Annals of Internal Medicine from: https://www.acpjournals.org/doi/10.7326/M19-1834

reported in recent studies which showed that **approximately 25% of internists and 46% of pediatricians** stated that they would opt for an alternative specialty if they could choose again.[9]

Policy Implications: Most states recognize the importance of enhancing primary care service delivery and have instituted different strategies to promote primary care. Many states have established multi-payer patient-centered medical home programs. Some states and payers have sought to elevate primary care by creating programs that incentivize primary care and specialists to work together; the best known of these models is the Centers for Medicare and Medicaid Services' Accountable Care Organizations (ACOs). In Maryland, the Total Cost of Care Model aims to engage hospitals and health care practitioners in a broad program to improve quality and slow the growth of total costs. Regardless of a program's scope – narrowly focused on primary care or encompassing the entire health care economy - increasing use of primary care is seen as a driver to slow the growth of total health care spending. Many advocates contend that a more significant investment in primary care will pay for itself over time by reducing the use of expensive specialty and inpatient hospital care, thereby lowering overall health spending.[10]

A pivotal strategy for promoting primary care delivery is measuring and reporting primary care costs and services. Reporting primary care spending encourages clear financial accountability for insurers, the public, or members of an integrated health care delivery system. It also creates a learning opportunity for all stakeholders and provides an evidence base for making critical policy decisions. Until recently, little or no information is available on tracking primary care spending in the privately insured market in Maryland.

MHCC's Initiative

A priority of the Maryland Health Care Commission (MHCC) is to support advanced primary care and practice transformation to improve coordinated care delivery and health outcomes. For the first time, MHCC commenced the tracking of primary care costs in its annual report titled "*Spending and Use among Maryland's Privately Insured, 2018.*"[11] In this report, primary care spending is defined as the cost (including provider reimbursement and insured member out of pocket amounts) of preventive services, including wellness programs, and the treatment of common illnesses rendered by physicians in an office or an outpatient facility setting. As noted in the report, spending was reported on a per capita basis for 2018. This report also showed primary care spending as a percentage of total per capita expenditure (all medical outpatient facility services and professional services, and prescription drugs). Results from the report found that the proportion of spending on primary care in Maryland was comparable to other states in the nation. Further details of the report and Milbank Memorial Fund definitions of primary care are included in the appendix.

[9] Primary Care Collaborative. Spending for Primary Care. Retrieved 06/04/2020 from: https://www.pcpcc.org/resource/spending-primary-care-fact-sheet

[10] Phillips, R.L., Bazemore, A.W. (2010). Primary Care And Why It Matters For U.S. Health System Reform. Health Affairs vol. 29, no. 5. Retrieved 07/01/2020 from: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0020

[11] Spending and Use among Maryland's Privately Fully-insured 2018, MHCC, May 2020. . Retrieved 07/01/2020 from https://mhcc.maryland.gov/mhcc/pages/plr/plr_healthmd/documents/cais_spending_use_among_MD_privately_insured_2018.pdf

Findings:

Primary care spending constituted about 4.6% of all medical and outpatient prescription drug spending in 2018. This was comparable to national benchmark percentages reported by the Milbank Memorial Fund.

- Annual primary care spending for all products combined increased substantially from 2017 to 2018, by about 6%, compared to a 2.5% increase from 2016 to 2017. (Exhibit 3).
- There was a steady decline in spending on primary care in the individual market from 3.8% in 2016 to 3.4% in 2018 (Exhibit 1). This may be attributed to the exit of relatively healthier enrollees who are more likely to use mostly primary care services.
- The percent annual spending on primary care was highest (12.4%) for ages 0-18 years compared to any other age group (Exhibit 2). Compared to adults, the higher primary care spending percent observed among this age group could be attributed to more primary care services required for brief recurrent illnesses and preventive care. Adults seek care mostly when there are significant morbidity or risk factors of concern.
- There were no remarkable differences in primary care spending by gender.
- The average annual expenditure for primary care services increased modestly from the 19 to 64-year age group throughout the study period. However, the percentage of primary care spending compared to overall spending declined with age, from 12.4% to 3.0% (Exhibit 2).
- When total spending was broken down by product, in 2018 PPO and EPO plans spent 4.2% and 4.6% respectively on primary care while HMO plans spent 5% on primary care (Exhibit 3). These data are comparable to national benchmark percentages reported by the Milbank Memorial Fund.

Exhibit 1: Annual Primary Care Spending vs. Total Medical and Outpatient Prescription Drug Spending by Market: 2016 – 2018

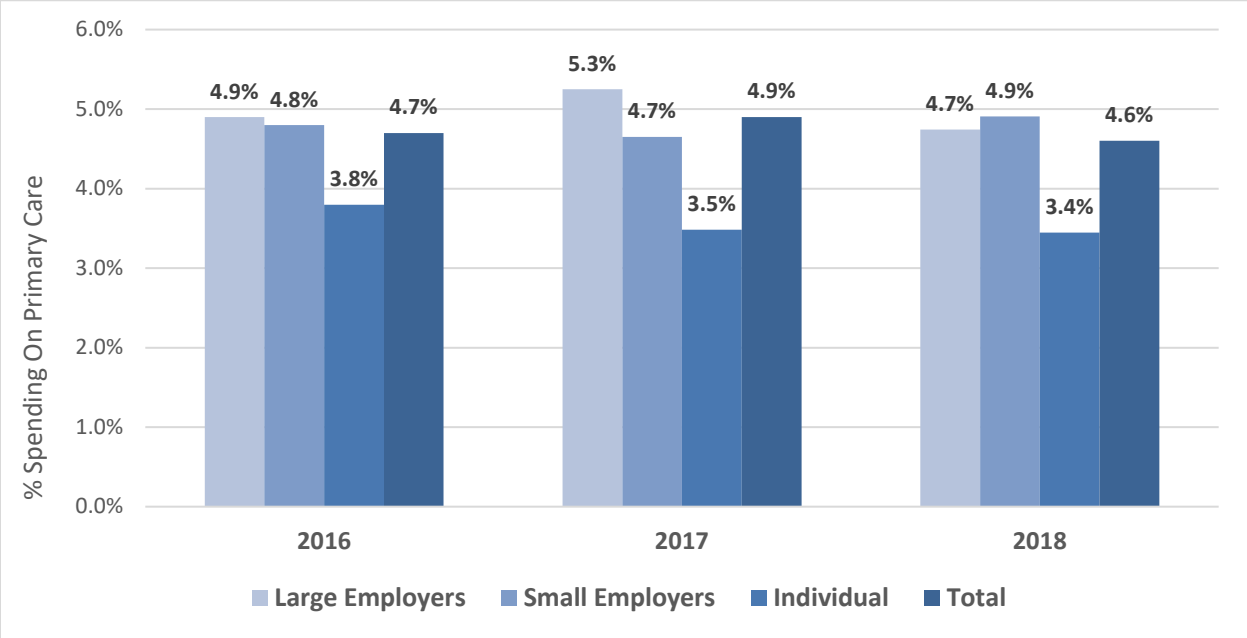

Exhibit 2: Annual Primary Care Spending vs. Total Medical and Outpatient Prescription Drug Spending by Age Group, 2018

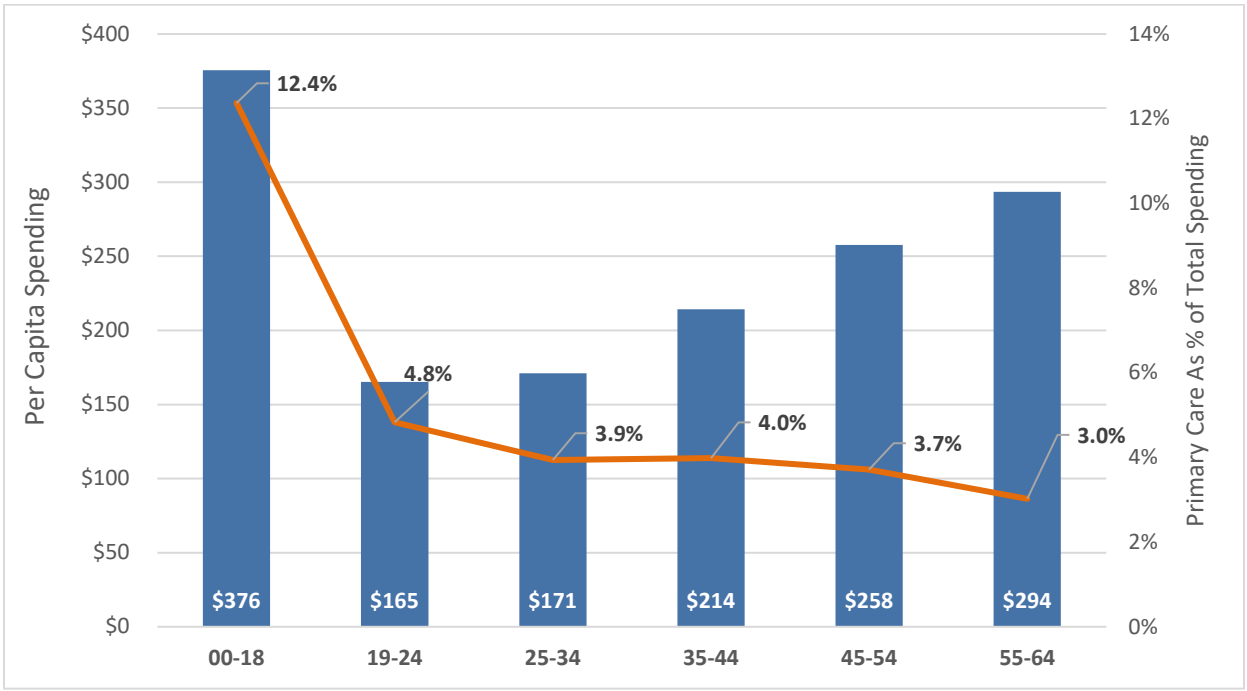

Exhibit 3: : Annual Primary Care Spending vs. Total Medical and Outpatient Prescription Drug Spending by Product: 2016 – 2018

Product	2016	2017	2018
Annual Primary Care Spending Per Member			
PPO	$258	$262	$276
EPO	$208	$230	$199
HMO	$233	$238	$261
POS	$258	$244	$257
All Products	**$240**	**$246**	**$261**
Annual Primary Care Spending as a % of Total Spending			
PPO	4.5%	5.0%	4.2%
EPO	4.4%	5.2%	4.6%
HMO	5.1%	5.0%	5.0%
POS	4.4%	4.4%	4.9%
All Products	**4.7%**	**4.9%**	**4.6%**

Experiences from other States that Track Primary Care Spending:

- **Connecticut**: The average percentage of the expenditure on primary care in Connecticut from 2014 to 2018 was 5%. This result was also comparable to the Maryland rate of primary care investment. In January 2020, Connecticut's governor issued an executive order which directs the Office of Health Strategy to establish statewide healthcare cost growth and quality benchmarks and a primary care spending target of 10% by calendar year 2025.[12]
- **Delaware:** In 2018, Delaware passed legislation that requires insurers to participate in the state's Primary Care Reform Collaborative. In 2019, this Collaborative issued a recommendation for a target of 12% investment in primary care.[4]
- **Oregon:** In 2017, Oregon passed legislation that sets a minimum primary care threshold for all commercial and public payers of at least 12% of total medical expenditures by 2023.
- **Rhode Island**: In Rhode Island, the state measured and increased its primary care spending from 5.7% in 2008 to 9.1% in 2012.[13]. In June 2020, Rhode Island updated its health care affordability standards. Under the new regulations, insurance carriers are required to spend at least 10.7% of total health expenditures on primary care.[14]
- **Maine**: The percentage of spending on primary care in Maine was 5.8 - 6.8% in 2018. While a floor on primary care spending has not been set, in June 2019, Maine passed legislation titled "An Act to Establish Transparency in Primary Health Care Spending," requiring insurers to report primary care expenditures to the Maine Health Data Organization, and for the Maine Quality Forum to use these data to report annually to the Department of Health and Human Services and the Legislature.[15]

[12] Milbank Memorial Fund, (2020). How Connecticut is Moving to Control Health Care Cost. Retrieved 05/28/2020 from: https://www.milbank.org/2020/03/how-connecticut-is-moving-to-control-health-care-costs/
[13] PCC Primary Care Investment. Retrieved 05/26/2020 from: https://www.pcpcc.org/primary-care-investment
[14] Rhode Islands Updated Affordability Standards Support Behavioral Health and Alternative Payment Models (2020). Milbank Memorial Fund. Retrieved 07102020 from: https://www.milbank.org/news/rhode-islands-updated-affordability-standards-to-support-behavioral-health-and-alternative-payment-models/
[15] Main Quality Forum. Measuring to Improve (2020). Retrieved 05/28/2020 from: https://www.pcpcc.org/sites/default/files/resources/MQF%20Primary%20Care%20Spending%20Report__Jan%202020.pdf

- **Washington**: The percentage of spending on primary care in Washington was 4.4% in 2018. This rate was comparable to Maryland. In 2019, Washington appropriated $110,000 for the fiscal year 2020 to determine annual primary care medical expenditures using the state's all-payer claims database and other existing data.[16]

Other states that have passed legislation to support or increase the proportion of spending allocated to primary care include Colorado, Vermont, West Virginia, Hawaii, and Massachusetts.[4]

Conclusions: Primary care spending as a percent of total spending in Maryland is comparable to other states that have tried to measure spending. All the state rates fell well behind the average expenditure on primary care (14%) in over 20 countries of the Organization for Economic Cooperation and Development (OECD).[17] In order to increase primary care services, policymakers must support the development of advanced primary care programs, report and track primary care spending, enact legislation to promote the utilization of primary care services, and set minimal levels of primary care spending for fully insured products. Increasing spending on primary care is possible. Rhode Island saw spending climb from 2008 to 2012 after the Insurance Commissioner ordered insurance carriers to elevate funding. Recent legislation sets even stronger targets: insurance carriers are required to spend 10.7% of premiums on primary care services. Providing incentives to specialize in primary care could also increase the attitude of medical students towards specializing in primary care[18].

Appendix

Primary Care Definitions and Measurement Methodology: Since the definitions and measurement of primary care providers and services are not yet standardized across institutions, MHCC deferred to methodologies used in a report published by the Milbank Memorial Fund in 2017.[19] The Milbank report classified four types of primary care definitions, "A through D", based on provider specialty only and provider specialty plus services rendered. MHCC evaluated the Milbank methodologies and selected the narrow PCP-B definition as that most closely aligned with how primary care in Maryland is conceptualized. Qualified providers were identified using industry-standard taxonomy codes. All data used in this report were retrieved from Maryland's Medical Care Database (MCDB), which contains health insurance enrollment, health care claims, and encounter data for Maryland residents.

Inclusion Criteria: Primary care providers include physicians in family medicine, general internal medicine, pediatrics, nurse practitioners, physician assistants, nurse non-practitioners, and homeopathic specialties. Services categorized as primary care include immunization, health risk assessment, office visits for new or established patients, telephone or home visits, smoking cessation, or health screening. Point

[16]Office of Financial Management, (2019). Primary Care Expenditures. Summary of Current Primary Care Expenditures and Investment in Washington. Retrieved 05/28/2020 from: https://www.ofm.wa.gov/sites/default/files/public/publications/PrimaryCareExpendituresReport.pdf
[17] Primary Care. Retrieved 05/27/2020 from: https://www.oecd.org/health/health-systems/primary-care.htm
[18] Beverly E.A., Reynolds S., Balbo, J.T. et. Al (2014). Changing first-year medical students' attitudes toward primary care. Family Medicine 46(9):707-12. Retrieved 1/24/2020 from: https://pubmed.ncbi.nlm.nih.gov/25275282/
19. Bailit, M.H., Friedberg, M.W., Houy, M.L. (2017). Standardizing the Measurement of Commercial Health Plan Primary Care Spending. (Retrieved 01/27/2020: https://www.milbank.org/publications/standardizing-measurement-commercial-health-plan-primary-care-spending/)

of service locations included rural health clinics, primary health clinics, federally qualified health centers, physician offices, and hospital outpatient departments.

Exclusion Criteria: Obstetrics and gynecology, geriatric, and psychiatry specialties were excluded. Claims incurred in emergency rooms and inpatient services were also excluded.

Qualified medical encounters for this analysis include all products (HMO and non-HMO) offered in the individual, small employer, and large employer markets.

Appendix Exhibit 1 - Annual Primary Care Spending vs. Total Medical and Outpatient Prescription Drug Spending: 2016 – 2018

	2016				2017				2018			
	Total	Large Employers	Small Employers	Individual	Total	Large Employers	Small Employers	Individual	Total	Large Employers	Small Employers	Individual
Annual Primary Care Spending Per Member												
Age												
00-18	$344	$351	$328	$317	$354	$361	$340	$314	$376	$382	$367	$329
19-24	$142	$144	$136	$136	$148	$152	$134	$137	$165	$167	$162	$152
25-34	$159	$162	$152	$157	$162	$165	$152	$157	$171	$176	$162	$159
35-44	$199	$205	$183	$188	$202	$211	$179	$186	$214	$224	$189	$190
45-54	$239	$248	$219	$217	$247	$259	$218	$219	$258	$272	$227	$216
55-64	$273	$286	$245	$245	$278	$293	$239	$247	$294	$313	$255	$250
Total	$240	$249	$221	$219	$246	$257	$221	$219	$261	$272	$237	$221
Annual Primary Care Spending as a % of Total Spending												
Age												
00-18	13.1%	13.5%	12.4%	11.3%	13.1%	13.8%	11.6%	10.3%	12.4%	12.6%	12.7%	9.9%
19-24	4.5%	4.6%	4.3%	4.3%	4.8%	5.1%	4.1%	4.0%	4.8%	5.0%	4.8%	4.0%
25-34	4.0%	4.2%	4.3%	3.0%	4.0%	4.3%	4.2%	2.7%	3.9%	4.1%	4.4%	2.8%
35-44	4.1%	4.3%	4.4%	3.2%	4.2%	4.5%	4.2%	2.9%	4.0%	4.1%	4.3%	3.0%
45-54	3.8%	3.8%	3.8%	3.4%	4.0%	4.2%	3.7%	3.2%	3.7%	3.8%	3.8%	3.2%
55-64	3.1%	3.2%	3.1%	3.0%	3.3%	3.5%	3.0%	2.8%	3.0%	3.0%	3.1%	2.9%
Total	4.7%	4.9%	4.8%	3.8%	4.9%	5.3%	4.7%	3.5%	4.6%	4.7%	4.9%	3.4%

Note: (1) Some calculations in the above exhibit might not be exact due to rounding.
(2) The large employer market includes the State of Maryland employees (self-insured non-ERISA) and other self-insured non-ERISA plans.
(3) Results exclude Kaiser health plans.

This issue brief was created by Center for Analysis and Information Systems staff (Kenneth Yeates-Trotman, Shankar Mesta, Oseizame Emasealu and Janet Ennis, Editor). Questions about the report should be directed to Oseizame Emasealu (Email: Oseizame.Emasealu@maryland.gov).

The Maryland Health Care Commission is an independent regulatory commission administratively located within the Maryland Department of Health.

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